DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G161	A. BUILDING _____ B. WING _____	05/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRYSALLIS	3765 FIRST STREET, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS Surveyor: 17620 A recertification survey was conducted from April 30, 2008 through May 2, 2008. The full survey process was utilized. A random sample of three clients was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports. The findings of the survey revealed that the facility failed to be in compliance with the Conditions of Participation in Governing Body, Client Protections, and Facility Staffing.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Surveyor: 16663 Based on observations, interviews, and record review, the facility failed to ensure that governing body consistently exercised general policy and operating direction over the facility (See W104); failed to ensure that each entry into a client's record was signed and dated (See W114); and failed to ensure that outside services met the needs of each client (See W120). The results of these systemic practices resulted in the Governing Body's failure to provide continuos active treatment services and maintain	W 102	W 102 In answer to W 102, the facility hereby cross-references and adopts the responses to W 104(3), W 149, W 114, W 120, W 122, and W 195. The Governing Body will more aggressively monitor the staff work performances and the operations of the facility to prevent a repeat of the concerns in W 102	On-going

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HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Glenn J. Williams, Esq	Pres. Int / CEO	06-11-2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 the client's health and safety. (See W122 and W195)	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on observation, interview and record review, the facility's Governing Body failed to monitor and/or revise its operation directions to ensure the health and safety of the clients. for six of six clients (Clients #1, #2, #3, #4, #5 and #6) that resided in the facility. The findings include: 1. The governing body failed establish and/or implement policies that ensured the client's health and safety. (See W149) 2. The governing body failed to ensure staff were effectively trained to manage each client's inappropriate behaviors including the use of specialized interventions. (See W189) 3. The facility's governing body failed to ensure the implementation its "Medication Disposal" policy as outlined. Observation of the evening medication administration on April 30, 2008 at 5:38 PM revealed Client #2 was administered Chlorpromazine HCL, Naltrexone Hydrochloride, and Topamax by the residential nurse. The nurse explained to the surveyor prior to attempting to	W 104	W 104 As answer to W 104, the facility hereby cross-references and adopts the answers to W 149 and W 189. The DON will continue to monitor the nurses' job performances to ensure consistent compliance with all medication administration policies. The Governing Body will ensure that all staff is re-trained with follow up re-training (60-90 days after 1st session) in concerned areas. Supervising staff will be required to provide job practice monitoring to assess carry-over of information and procedures that reflect current policies of the organization.	06-10-2008 06-16-2008 09-05-2008

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W 104	Continued From page 2 give Client #2 his medications (tablets) that the client sometimes would slap the medication cup from her hand. When the nurse attempted to give the client the medication, Client #2 slapped the medication cup from the the nurse's hand, spilling the tablets on the floor. The nurse was then observed to pick up the spilled tablets and administered Client #2 replacement medications. At 5:51 PM, the nurse disposed of the spilled tablets by placing the medications in the trash in the nurses' station. The trash bag was immediately taken outside and disposed of in the facility's external garbage receptacle. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's "Medication Disposal" policy on May 2, 2008, indicated that contaminated single dose drugs should be disposed of utilizing a witness method. The drug should be "flushed down the drain" documented and a witness should sign off indicating the event was observed. At the time of the survey, the facility failed to ensure its medication destruction policy had been implemented as outlined.	W 104		
W 110	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that includes a separate record for each client. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on interview and record review, the facility failed to maintain a completed and comprehensive medical assessment on file, for one of the three clients (Client #2) included in the sample.	W 110		

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W 110	Continued From page 3 The finding includes: The facility failed to ensure a complete medical assessment was available for review as evidenced below: Review of Client #2's medical record on May 2, 2008, at 12:18 PM revealed a medical assessment dated November 8, 2007. Further review of the client's medical assessment revealed that it had not been signed or dated by the Primary Care Physician (PCP). Interview with the facility's Registered Nurse on May 2, 2008, revealed that some pages were missing from the assessment. At the time of the survey, there was no documented evidence that the client's medical record was maintained.	W 110	W 110 As answer to W 110, the facility says follows: 1. Client # 2 medical assessment was pulled during other third party monitoring visits prior to the survey, and subsequently incorrectly filed. This error was corrected on 5/03/08. The DON and the QMRP will monitor to ensure consistent compliance with proper filing procedures.	05-03-2008
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure that each entry into a client's record was signed and dated, for one of three clients (Client #1) included in the sample. The finding includes: Observation of the medication administration on April 30, 2008 at 5:33 PM revealed the client was administered his medication (Carbidopa/Levodopa). Review of Client #1's April 2008 Physician's Orders (POS) on May 2, 2008 at 12:15 PM revealed an order for	W 114		

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W 114	Continued From page 4 Erythromycin Ophthalmology 5mg/gm ointment to be applied to each eye every evening. Continued review of the POS revealed the hand written notation "D/C'd" was documented adjacent to the Erythromycin order. It should be noted that notation failed to be signed or dated by the person that made the notation. Additionally, the printed POS had an area designed on the form for the documentation of discontinued medications. The area made provision for date, time, and person's initials to be documented. At the time of the survey, the facility failed to ensure the notation made on Client #1's April 2008 POS was signed and dated.	W 114	W 114 As answer to W 114, the facility says follows: The nurse has been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will more aggressively monitor entries in clients' records to ensure consistent compliance with recording procedures.	06-10-2008
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of one of the three clients (Client #1) included in the sample. The findings include: The facility failed to ensure that Client #3's day program administered medications in compliance with his physician's orders. Interview with the day program's nurse on May 1, 2008 at 11:25 AM revealed Client #3 received ear drops when needed (PRN) at the day program for pain. Further interview with the day program's nurse revealed that Client #3 cried, beat on his	W 120		

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W 120	Continued From page 5	W 120		

ears and pushed objects out of his way, as an indication to the staff that he was experiencing pain. Whenever the client exhibited any of the aforementioned behaviors, the day program staff would call for the nurse and the ear drops would be administered.

Review of Client #3's day program's medical record on May 1, 2008, revealed a physician's order dated May 2007. According to the physician's orders, Client #3 was prescribed Aurodex drops" to both ears twice daily split one for day program" (start date April 26, 2007). Continued interview with the day program's nurse verified that Client #3 only received the ear drops as needed for pain. The nurse's statement was further verified through review of the day programs Medication Administration Records (MAR) on May 1, 2008. The MARs for the months of June 2007 through February 2008 failed to provide evidence that the client received the ear drops on a daily basis as ordered.

At the time of the survey the facility failed to ensure Client #3 received medication in accordance with the physician's order.

The facility failed to ensure Client #1's day program implemented the client's Behavior Support Plan (BSP) and failed to intervene in the client's behavior of head slapping.

A. The facility failed to ensure Client #1's BSP was implemented at the day program.

Observation at Client #1's day program on May 1, 2008 at 12:01 PM revealed the client intermittently grabbing the staff member's lower forearm (near wrist) while the staff member was

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W 120	Continued From page 6	W 120		

engaging the client and class in a craft project (sewing). The staff member revealed that the client likes to touch. At approximately 12:10 PM, the staff person was overheard telling Client #1 to stop grabbing her hand.

Interview was conducted with the day program's staff member on May 1, 2008 at 12:26 PM to ascertain if the client had a BSP at the day program. The staff member revealed the client had a BSP and produced the plan for review. The plan (last revised on February 1, 2007) revealed the following a program goal:

"[Client #1] will refrain from tapping or grabbing others more than 3 times on the monthly average per 20 minute sampling period for 3 consecutive months."

Additional review of the plan revealed interventions including the following:

Staff should shake [Client #1's] hand or give him pats on the back or shoulder every 5-7 minutes. These contacts should be brief.

If [Client #1] taps on a staff member or program participant, he should be redirected to an activity.

It should be noted that observation between 12:01 PM and 12:34 PM evidence that the aforementioned strategies were implemented.

B. The facility failed to ensure the day program intervened in Client #1's behavior of head slapping.

Observation at Client #1's day program on May 1, 2008 at 12:05 PM, revealed Client #1 hit the left

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W 120	Continued From page 7 side of his head with his left hand and then made a grunting sound. At 12:06 PM, the client was again observed to hit himself on the head. At 12:10 PM, Client #1 was observed to hit his head with his left hand and then began to shake his left hand as it was positioned in front of his face (with his thumb closest to his nose). The client was observed to intermittently hit his head with his left hand at 12:15 PM, 12:16 PM, 12:18 PM, 12:28 PM and 12:34 PM. It should be noted that staff was not observed to intervene. Interview was conducted with the day program's staff member on May 1, 2008 at 12:26 PM to ascertain if the client had a BSP at the day program. According to the staff member Client #1 had a BSP that addressed the client's behaviors of grabbing others. Additionally, the staff member revealed that the client had a behavior of hitting himself. Review of the plan (last revised on February 1, 2007) verified the staff member's statement and documented a program objective that addressed the client's tapping/grabbing behavior. The plan further revealed that baseline data was being collected on the self-injurious behavior of head-slapping. At the time of the survey, the facility failed to ensure the day program intervened in the client's known and observed head slapping behavior. C. The facility failed to ensure the day program implemented/developed a protocol to address Client #1's cloth chewing behavior. Observation at Client #1's day program on May 1, 2008 at 12:06 PM, revealed the client pulling a long piece of cloth (approximately 1" to 1 1/2" in width and 6" in length) from his mouth, the client then placed it on the table in front of him. At	W 120	W120 C The QMRP will meet with day program on 6/09/2008 to review and update their protocol for managing client # 1 cloth chewing behavior in a safe and sanitary manner. The facility hence forth will more aggressively monitor the services client # 1 and indeed the other clients of the facility receive in their day programs.	06-09-2008 On-going

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W 120	Continued From page 8	W 120		

12:11 PM, Client #1 was observed to pick the cloth up from the table, briefly held it, and then placed it back on the table when the staff member asked the client if he wanted to participate in the class project (sewing). At 12:17 PM, the client was observed to pick the cloth up from the table, placed it in his mouth, and then put it back on the table. The client was neither observed to wash his hands nor was the table observed to be cleaned.

Interview was conducted with the day program's staff member on May 1, 2008 at 12:26 PM to ascertain if the client had a BSP at the day program. According to the staff member Client #1 had a BSP that addressed the client's behaviors of grabbing others. Additionally, the staff member revealed that the client had a behavior of hitting himself. Review of the plan (last revised on February 1, 2007) verified the staff member's statement and documented a program objective that addressed the client's tapping/grabbing behavior. It should be noted that the cloth chewing was not addressed.

Review of Client #1's residential records on May 2, 2008 at approximately 7:40 PM revealed the client had a "Standard Procedure" dated April 10, 2007 that addressed the client's clothe tearing behavior. According to the documented procedure in the section entitled, "Goal/Compromise/Human Rights Solution," Client #1 has had a "long-standing deeply entrenched behavior" of chewing. The plan further documented that the "chewing has never caused any acute danger to [Client #1], there have been difficulties when people have tried to take the pica items away from him. Nevertheless, there could be an ongoing risk of germs and

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W 120	Continued From page 9 infection, the property destruction issue, and the inappropriate social stigma. A compromise has been developed in which [Client #1] will be given clean squares of cloth to chew on during his relaxation times and when these get chewed up that is, munched up and withered looking, he will be asked to exchange these for fresh clean squares of cloth." Continued review of the plan revealed a section entitled, "Sucking." According to that section, Client #1 was to be supplied cloth pieces to chew on that were "at least 6" X 6" so that staff could pull them out of his mouth if he starts to choke or resists giving one up." The plan further documented that, "once he has chewed on a clean cloth square for a while, it should be thrown away and [Client #1] should be offered a new one. When he gives up the old one and gets a new one, staff should verbally praise him. Every fifth time he exchanges the old chewed up cloth for a new one, staff should also give him an edible reward, that is consistent with his diet." At the time of the survey, the facility failed to ensure the day program developed/implemented an active protocol that consistently addressed the management of Client #1's chewing behavior in a safe and sanitary manner. (See also W149)	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the facility failed to ensure each client's	W 122		

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W 122	Continued From page 10 right to privacy [See W130]; failed to ensure parents/guardians were notified of serious incidents [See W148]; failed to implement policies and procedures that ensured clients' health and safety [See W149]; failed to ensure that all injuries of unknown source and allegations of abuse were reported [See W153]; and failed to ensure all allegations of abuse and injuries of unknown source were investigated [W154]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	W 122	W 122 The facility has always and consistently been protecting its clients and ensuring their health and safety. The facility notifies parents/guardians of serious incidents as required by the facility's incident management policy. Please refer to responses under referenced tag nos: W130, W148, W149, W153 and W154.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the three clients (Clients #1 and #2) included in the sample. The finding includes: 1. Review of Client #1 ' s medical record on May 2, 2008 at 1:16 PM revealed a written order	W 124		

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W 124	Continued From page 11 (dated February 21, 2008) for the client to receive Diazepam 10 mg by mouth one hour before a medical appointment. The order further indicated that an additional 5 mgs may be given if the initial 10 mg dose did not sedate the client enough. Continued review of Client #1' s record on May 2, 2008 at 3:39 PM revealed a neurology consult sheet dated April 2, 2008. According to the consultation sheet, the client had a MRI of his brain on February 25, 2008. The consultation sheet further revealed that the client was sedated with Diazepam 10 mg one hour before the MRI. Additionally, the sheet revealed that the MRI could not be completed because the client would not lay back for the test. Interview with the facility ' s Registered Nurse (RN) on May 2, 2008, verified that the sedation was given and further verified that the test could not be conducted due to the client ' s inability to comply with the requirements for the test (lay back). Interview with the facility ' s House Manager (HM) was conducted on April 30, 2008 at 10:14 AM to ascertain if Client #1 had the ability to give informed consent for the use of medications, finance, and habilitation services. The HM revealed that the client did not have the capacity to give informed. The HM further revealed that the client had a legal guardian. The HM' s statement was verified through review Client #1 ' s Psychological Assessment (dated April 2, 2008) on May 2, 2008 at 7:37 PM. According to the assessment, Client #1 " does not evidence the decision making capacity on his own behalf in granting , refusing and/or withdrawing consent to medical treatments; regarding treatments other than medical ...and he does not have the capacity to execute a durable power of attorney. " At the	W 124	The facility protects and ensures the rights of all its clients. As further response to W 124, the facility says as follows: Client # 2 has a father who is involved in his life. Client # 2's father has actively participated in the psychotropic medication review of his son a number of times and he was informed of the medications, risk and side effects of the medications used in managing client # 2 behaviors. However, the facility has made additional review of its psychotropic/sedation medication information system and will henceforth more aggressively inform and obtain written, separate consent from parents/legal guardians on the use of medications, including sedations when needed for critical medical appointments including clients # 1 and #2. The QMRP will coordinate with nursing/medical to ensure that all parents/legal guardians are consistently informed of all needed sedations and psychotropic medications including their attendant risks, side effects and the right to refuse treatment. An informed consent form has been created to ensure a proper documentation of this process.	06-18-2008 On-going

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W 124	Continued From page 12	W 124		

time of the survey, the facility failed to provide evidence that Client #1' s legal guardian was informed of the sedation prior to its use.

2. The facility failed to provide evidence that informed consent was obtained from Client #2 and/or his legal guardian for psychotropic medications.

Observation of the evening medication administration on April 30, 2008 at approximately 5:38 PM revealed Client #2 received medications including Chlorpromazine 200 mg, Naltrexone Hydrochloride 50 mg,Topamax 100 mg, and Topamax 200 mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors.

Interview with the House Manager on April 30, 2008 at 10:14 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The House Manager's statement was verified on May 2, 2008 at 2:13 PM through review of Client #2's psychological assessment dated November 14, 2007. According to the assessment, Client #2 "does not evidence the decision making capacity on his own behalf in granting refusing, and/or withdrawing consent to medical treatments; regarding treatments other than medical, regarding habilitation, day programming or work; regarding type and place of residence; regarding finances; and/or regarding life planning; and he does not have the capacity to execute a durable power of attorney." Interview with the QMRP on May 2, 2008 revealed Client #2 did have family involvement (father) however, at the time of the survey there was no documented evidence that

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W 124	Continued From page 13 the client had a legal guardian. The QMRP was then queried to ascertain if Client #2 and/or his legally authorized representative was informed of the psychotropic medications to determine if consent was obtained for the medication. The QMRP revealed that there were consents obtained from Client #2's father located in his record. However, review of Client #2's record and further discussion with the QMRP failed to provide evidence that any type of consent (written and/or informed) had been obtained prior to the aforementioned psychotropic medications. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from Client #2 and/or legally authorized representative for his psychotropic medications.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, the facility failed to ensure each client's right to privacy, for two of the three clients (Clients #1 and 3) included in the sample. The findings include: 1. Observations conducted on May 2, 2008, at 4:36 PM revealed Client #3 received staff assistance while using the bathroom. The client was observed seated on the toilet with the bathroom door opened. At the time of the survey,	W 130	W 130 In response to W 130, the facility says that it ensures privacy of all of its clients, including client # 1 and 3, during all treatments and care of personal needs. Further, [1.] Staff is instructed to monitor client # 3 while using the bathroom because client # 3 fainted while using the bathroom in 20007 and was taken to hospital, treated and discharged. However, the facility will conduct further staff training on client privacy rights and protection to ensure a reasonable balance between monitoring client # 3 and the need to protect his privacy at all times.	06-05-2008

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W 130	Continued From page 14 the facility failed to ensure the client's right to privacy was provided during his personal care. 2. Observation of Client #1 on May 1, 2008 at 5:46 PM, revealed Client #1 was observed with his buttocks exposed in the television room (pants down). Client #4's 1:1 attempted to assist Client #1 by escorting him from the television room through the dining room (with his buttocks still exposed and Client #4 accompanying them) to get dressed. It should be noted that at the time of the aforementioned observation, the staff member assigned to work with Clients #1, #3 and #6 was assisting the QMRP and another staff member with a behavioral episode involving Client #2. At the time of the survey, the facility failed to ensure Client #1's right to privacy during dressing.	W 130	[2.]. When client # 2 went into an explosive behavior and sought to attack a surveyor in the home, an emergency situation erupted. The staff assigned to client # 1 turned to provide assistance in an emergency situation to prevent a surveyor from being hit. It was mere reflex action on the part of the staff with the motive of ensuring safety of a surveyor. Unfortunately, within this short time client # 1 exposed his buttocks (reason unknown). The staff in question and other staff members will be retrained on privacy issues and protections. The staff will also be retrained on how to respond in crisis situations.	06-05-2008
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure parents/guardians were notified of serious incidents, for two of the six clients (Clients #1 and #6) that resided in the facility. The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of	W 148		

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W 148	Continued From page 15 the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at 2:11 PM revealed the following: a. On December 31, 2007, staff reported that Client #1 had been taken to the emergency room due to prolonged diarrhea and some vomiting. The client was released on January 1, 2008 with a diagnosis of gastroenteritis. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed Client #1 had a legal guardian that was involved with his care. Continued review of the facility's incident reports failed to provide evidence that the client's legal guardian had been notified of the aforementioned incident. b. On September 12, 2007, staff reported that Client #1 was weak upon returning from a community outing at the day program. The client was sent via ambulance to the emergency room for evaluation. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed Client #1 had a legal guardian that was involved with his care. Continued review of the facility's incident reports failed to provide evidence that the client's legal guardian had been notified of the aforementioned incident. c. On December 31, 2007, staff reported that Client #6 was picked up from his day program and was unable to walk. Client #6 was subsequently taken to the emergency room to be evaluated. The client was treated for fatigue and was released on January 1, 2008. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed that Client #6 had a legal guardian and a mother that was involved in his care. Review of the facility's incident reports however, failed to provide evidence that the legal guardian and	W 148	W 148 As response to W 148, the facility says as follows: The facility has always notified the parents /guardians and DDS case managers of any serious incident involving clients # 1 and # 6 as well as the other clients of the facility. The notification is always by telephone and was not noted on the incident reports reviewed by the surveyor. This oversight is noted and will be avoided henceforth. All telephone notifications to parents/guardians and Case Managers will be reflected henceforth on the file copy of the incident report in the home. The QMRP will provide more oversight to the operations of the incident management coordinator. The CEO will more consistently supervise the QMRP to assure that all notifications to parents/ guardians and Case managers are documented in the file copy of the incident report in the home to facilitate the implementation of the facility's incident management policy.	06-04-2008 On-going

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W 148	Continued From page 16 mother were notified of the aforementioned incident. d. On October 25, staff reported that Client #2 "fell up the stairs to the doctor's office." Continued review of the report revealed the client was observed to hit his mouth on the cement and cracked his right front tooth. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed that Client #2 had a father that was involved in his care. Review of the facility's incident reports however, failed to provide evidence that the client's father had been notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the facility failed to establish and/or implement policies that ensured the client's health and safety, for two of the three clients (Clients #1 and #2) that resided in the facility. The findings include: 1. The facility failed to ensure the implementation of its "Incident Management" policy as outlined. Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on May 1, 2008, beginning at 2:11 PM revealed the following:	W 149		

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W 149	Continued From page 17 a. On October 22, 2007, staff reported observing an "abrasion or bruise" on Client #1's left leg. b. On August 10, 2007, staff reported discovering a bruise on Client #2's right knee. c. On August 9, 2007, staff reported discovering a bruise on Client #2's left shoulder. d. On November 12, 2007, the nurse reported that Client #1's lower lip was swollen. Continued review of the facility's incidents reports failed to provide evidence that the aforementioned incidents were reported immediately to the administrator or to other officials in accordance with State law. Additionally, there was no evidence that the incidents that occurred on October 22, 2007 and November 12, 2007, were investigated. Interview with the QMRP on May 2, 2008 at 11:32 AM revealed that whenever an incident occurred either the QMRP or the House Manager's (HM) was responsible for notifying the administrator (also the Registered Nurse) Additionally, the QMRP indicated that it was his responsibility to ensure the incident report was taken to the main office to the Incident Management Coordinator (IMC). Continued interview with the QMRP revealed that the IMC was responsible for making a decision as to whether or not an investigation needed to be conducted for a serious reportable and/or reportable incidents. The QMRP indicated that the administrator was required to review and sign the investigation after it's completion. The QMRP	W 149	W 149 The facility has always and consistently been protecting its clients and ensuring their health and safety. [1.] The injuries listed in W. 149 involve clients who are on BSP for self injurious behaviors. Client # 1 has a diagnosis of vertiligo, which results in occasional break up of skin. He is on medical treatment and monitoring for this problem. Client # 2 was base-lined for abusing himself which resulted in developing a BSP targeting self injurious behavior in November, 2007. The incident management coordinator shall follow company policy and investigate all incidents of unknown origin; only the outcome of an investigation will determine whether they are considered serious reportable or reportable incidents. Such investigation reports shall be filed with the incident report and kept in the facility record. The QMRP will maintain oversight in the process.	06-04-2008 On-going

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W 149	Continued From page 18 was uncertain about the length of time (thought it was three days) allotted for the completion and review of an investigation. Review of the facility's "Incident Management" policy on May 2, 2008 revealed that all serious reportable incidents required immediate notification to be made to the facility's Incident Management Coordinator (IMC) and administration. It should be further noted that the policy revealed that internal investigations on all serious reportable incidents would begin within 12 hours of the incident being witnessed or discovered. Additionally, the policy revealed that "all investigations shall be completed within five (5) working days of the incident." At the time of the survey, the facility failed to ensure its "Incident Management" policy was implemented as outlined. 2. The facility failed to ensure Client #1's behavior protocol was implemented as outlined. Observation of Client #1 on May 1, 2008, beginning at 4:44 PM revealed the client taking a piece of cloth out of his mouth (cloth was approximately 1" to 1 1/2 in width and 6" in length). After removing the cloth from his mouth, the client placed the cloth on the green chair located in the television room. The client was then observed to pick the cloth back up and put it on a green striped chair. The client was then observed to pick the cloth up and place it on the counter (located outside of the kitchen), touch the ground, pick it up off of the counter, and place it on a striped chair in the TV room. At 5:01 PM, the client was observed to place the cloth back in his mouth.	W 149		

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W 149	Continued From page 19 At 5:24 PM, Client #1 was observed to take the cloth out of his mouth and put it on a chair in the television room. The client was then observed to pick the cloth up and place it on the counter (located outside of the kitchen). Client #1 picked the cloth up from the counter and placed it on the ground. After picking the cloth up from the floor, the client was observed to tap the surveyor twice and then placed the cloth back into his mouth at 5:30 PM. At 5:33 PM, Client #1 was observed to put the piece of cloth on the floor and then placed it back into his mouth. At 5:43 PM, Client #1 was observed to put the cloth on the couch in the television room and then put it directly into his mouth. It should be noted that at the time of the aforementioned observations, the staff member assigned to work with Clients #1, #3, and #6 was assisting the QMRP and another staff member with a behavioral episode involving Client #2. Review of Client #1's record on May 2, 2008 at approximately 7:40 PM revealed the client had a "Standard Procedure" dated April 10, 2007 that addressed the client's clothe tearing behavior. According to the documented procedure in the section entitled , "Goal/Compromise/Human Rights Solution," Client #1 has had a "long-standing deeply entrenched behavior" of chewing. The plan further documented that the "chewing has never caused any acute danger to [Client #1], there have been difficulties when people have tried to take the pica items away from him. Nevertheless, there could be an ongoing risk of germs and infection, the property destruction issue, and the inappropriate social stigma. A compromise has been developed in which [Client #1] will be given clean squares of cloth to chew on during his relaxation times and when these get chewed up that is, munched up	W 149	W149 [2.] The facility shall implement the "Standard Procedure" designed for client 1 as written. The facility has a protocol for client # 1 cloth chewing behavior which the staff implements. However, the emergency situation created by client # 2 explosive behavior against a surveyor affected the staff assigned to client # 1 and he was unable to attend to client #1 at the material moment. However, the staff has since been instructed on how to respond in such emergency in the home. He will also benefit from a personal care training scheduled in the facility	06-16-2008 On-going

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W 149	Continued From page 20 and withered looking, he will be asked to exchange these for fresh clean squares of cloth." Continued review of the plan revealed a section entitled, "Sucking." According to that section, Client #1 was to be supplied cloth pieces to chew on that were "at least 6" X 6" so that staff could pull them out of his mouth if he starts to choke or resists giving one up." The plan further documented that, "once he has chewed on a clean cloth square for a while, it should be thrown away and [Client #1] should be offered a new one. When he gives up the old one and gets a new one, staff should verbally praise him. Every fifth time he exchanges the old chewed up cloth for a new one, staff should also give him an edible reward, that is consistent with his diet." At the time of the survey, the facility failed to ensure the consistent implementation of Client #1's "Standard Procedure" that addressed his tearing behavior by making certain he was provided with appropriately sized and sanitary cloths as stipulated.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure that all allegations of abuse and injurious of unknown source were immediately	W 153		

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W 153	Continued From page 21 reported to the administrator or to other officials in accordance with State law, for two of the three clients (Clients #1 and #2) that included the sample. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at 2:11 PM revealed the following: a. On October 22, 2007, staff reported observing an "abrasion or bruise" on Client #1's left leg. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. b. On August 10, 2007, staff reported discovering a bruise on Client #2's right knee. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. c. On August 9, 2007, staff reported discovering a bruise on Client #2's left shoulder. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. d. On November 12, 2007, the nurse reported that Client #1's lower lip was swollen. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other	W 153	W 153 The administrator of the facility was immediately informed of all the incidents involving clients # 1 2 and 4 referenced as required by policy and procedure. However, the information was done directly and on telephone as and when the incidents occur. The information to the administrator was not reflected on the incident reports reviewed by the surveyors. The facility has reviewed this information system and made changes. Henceforth, all incident report information given to the administrator directly and on phone will be noted on the file copy of the in incident report as additional note. The QMRP will more aggressively review all incident reports weekly to ensure that all needed information are accordingly reflected on the file copy of incident reports.	06-04-2008 On-going

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W 153	Continued From page 22 officials in accordance with State law. e. On March 16, 2008, staff reported observing an "abrasion" on Client #4's left knee. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. At the time of the survey, the facility failed to provide evidence that the administrator and/or other officials were immediately notified of the aforementioned incidents as required.	W 153	W 154 The facility has always and consistently been protecting its clients and ensuring their health and safety. [1.] The injuries listed in W. 154 involve clients who are on BSP for self injurious behaviors. Client # 1 has a diagnosis of vertiligo, which results in occasional break up of skin. He is on medical treatment and monitoring for this problem. Client # 2 was base-lined for abusing himself which resulted in developing a BSP targeting self injurious behavior in November, 2007. Further, client # 4 has a self-injurious behavior plan as well.	06-04-2008
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated, for two of the six clients (Clients #1and #4) residing in the facility. The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on May 1, 2008, beginning at 2:11 PM revealed the following: a. On October 22, 2007, staff reported observing an "abrasion or bruise" on Client #1's left leg. Continued review of the facility's incidents failed to provide evidence that the incident had been investigated.	W 154	The incident management coordinator shall follow company policy and investigate all incidents of unknown origin; only the outcome of an investigation will determine whether they are considered serious reportable or reportable incidents. Such investigation reports shall be filed with the incident report and kept in the facility record. The QMRP will maintain oversight in the process.	On-going

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W 154	Continued From page 23 b. On November 12, 2007, the nurse reported that Client #1's lower lip was swollen. Continued review of the facility's incidents failed to provide evidence that the incident had been investigated. c. On March 16, 2008, staff reported observing an "abrasion" on Client #4's left knee. Continued review of the facility's incidents failed to provide evidence that the incident had been investigated.	W 154		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Surveyor: 16663 Based on observations, interviews, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently [See W189];and failed to ensure staff were able to demonstrate the skills and techniques necessary to administer interventions to manage each client's behaviors [See W193]. The effects of these systemic practices resulted in the facility's failure to provide adequate staffing to ensure continuous active treatment services and the protection of client's health and safety. [See also W122]	W 158	W 158 The facility ensures that staffing requirements are met by providing pre-employment training, initial hire mentoring on the job and subsequent in-service training in core service delivery areas specific to the individuals served through out the year and annually. The QMRP shall more effectively monitor the staff for their ability to demonstrate the skills and techniques taught during their actual job practice periodically through the year. Staff re-training will be reflective of job practice observations. Documentation of all training efforts and a mentoring checklist shall be maintained in the record.	06-16-2008 On-going
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

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W 159	Continued From page 24 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure that outside services met the needs of each client. (See W120) 2. The QMRP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. (See W189) 3. The QMRP failed to ensure staff were capable of demonstrating the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients (See W193). 4. The QMRP failed to ensure each client received continuous active treatment services. (See W196) 5. The QMRP failed to ensure that as soon as the Interdisciplinary Team (IDT) formulated each client' s Individual Program Plan (IPP), clients received continuous active treatment, consisting	W 159	W 159 In response to W 159(1), the facility hereby cross-references and adopts the answers contained in W 120. In response to W 159(2), the facility hereby cross-references and adopts the answers contained in W 189. In answer to W 159(3), the facility hereby cross-references and adopts the answers contained in W 189. In answer to W 159(4), the facility hereby cross-references and adopts the responses contained in W 249. In answer to W 159(5), the facility hereby cross-references and adopts the answers contained in W 249. In answer to W 159(6), the facility hereby cross-references and adopts the answers contained in W 149.	

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W 159	Continued From page 25 of needed interventions and services. (See W249) 6. The QMRP failed to ensure Client #1 was provided with pieces of cloth that were safe and sanitary as specified in the client's documented protocol. (See W149)	W 159	W 189 As answer to W 189, the facility says as follows:	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: I. The facility failed to provide evidence that Client #2's 1:1 staff was trained on his Behavior Support Plan (BSP) including the use of special techniques/interventions to manage the client's inappropriate behavior. Observations on May 1, 2008 beginning at 5:09 PM revealed a 1:1 direct care staff (Staff #1) escorting Client #2 to the facility's TV room. At 5:15 PM, the client and his 1:1 staff were observed seated on the sofa in the in the TV room directly behind Surveyor A. At approximately 5:26 PM, Surveyor B observed	W 189	[1.] The new hire was given basic orientation and training by the House manager in the home during the absence of the QMRP due to illness. There was no signature sheet made for the training. The QMRP subsequently returned to the facility and again gave training to client # 2's 1:1 evening staff based on client # 2 BSP and general job orientation. Again, no signature sheet was made to evidence this training. The facility conducted a BSP training on 1/25/08 prior the hiring of client # 2's 1:1 evening staff. The plan was to arrange for a more comprehensive training that will be conducted by the Behavior specialist for client # 2's 1:1 evening staff. 2. Both the QMRP and the House manager have received instructions and directions from the CEO to make have the detailed agenda and signature sheet for all in house training no matter the circumstances. 3. Human Resources and the CEO shall more aggressively monitor all training documentations to ensure	

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W 189	Continued From page 26 Client #2 heading rapidly towards Surveyor A with both of his arms extended (Surveyor A's back was facing the client). Surveyor B assisted Surveyor A by moving Surveyor A out of the reach of Client #2. The client was observed to be physically aggressive and began to yell and scream. Continued observation during the aggressive episode revealed Client #2's 1:1 staff (Staff #1) attempted to prevent the aggression towards Surveyor A by pulling the client. Client #2 was then observed to head down the hallway towards his bedroom, but prior to getting to the hallway, Client #2 hit Surveyor A. Afterwards, Client #2 proceeded down the hallway with his 1:1 staff person holding onto his arm. At that time, the direct care staff person assigned to work with Clients #1, #3 and #6 (Staff #2) and the Qualified Mental Retardation Professional (QMRP) were observed to assist in the intervention of Client #2's behavior. The three staff were observed to have difficulty redirecting the client. They were observed to restrain both of Client #2's arms for approximately three minutes. Once the client appeared to be calm the staff escorted Client #2 outside of the facility. Interview with the QMRP on May 2, 2008 at 5:30 PM revealed that Client #2 had a Behavior Support Plan (BSP) that addressed behaviors of self injurious behaviors, physical aggression (such as scratching and hitting people) and throwing objects. The QMRP's statement was verified on May 2, 2008 through review of Client #2's BSP dated November 17, 2007. According to the plan, in a section entitled "Intervention Procedures for Physical Aggression," the following procedures were to be implemented:	W 189	that records are properly kept and available for inspections. 4. The facility's CPI trainings are conducted by Department of Disability Services (DDS) authorized trainer. DDS suspended CPI training in February, 2008. DDS has now resumed the training, but the DDS trainer will not be available to train staff until after November, 2008 when she will return from maternity leave. 5. As a result the aforesaid DDS CPI training schedule, client # 2 1:1 staff could not receive CPI training at time of the survey. Also the QMRP who was trained could not re-train at the time of the survey, and staff # 2 who had received CPI training but needed to re-train and pass the test could not do that before survey. Copies of QMRP and staff # 2 last training documentations are hereby attached.	06-16-2008

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1. If [client's name] engages in aggression, he will be given the verbal directive, "Stop [client's name]." At the time of the observation, the three staff were not observed giving a directive for Client #2 to " stop."

2. If [client's name] continues displaying aggressive behaviors staff should assume the "CPI Supportive Stance" as trained in the "Non-Violence Crisis Intervention Program." Interview was conducted with the QMRP on May 1, 2008 at 5:30 PM to ascertain information regarding which staff was trained on specialized techniques to manage inappropriate behavior (CPI Supportive Stance and Non-Violence Crisis Intervention Techniques). At the time of the survey, the facility failed to provide evidence that the QMRP, Staff 1 and Staff 2 had been trained in the aforementioned techniques. It should be noted that during the observation there was no evidence that the staff addressing Client #2's behaviors assumed the supportive stance documented in the client's BSP.

3. Staff should remember to consider such things as personal space (remain about 1-3 feet away) and body posture/motion (keep your hands open and facing upward). At the time of the observation, the three staff were in close proximity of Client #2. Additionally, the staff's hands were not positioned as indicated in the aforementioned intervention. It should noted that all three staff were observed to restrain the client's arms.

4. In the event that the behavior escalates, staff will utilize a block technique (learned in NVCI, see instructors' Manual) to interrupt the behavior(s).

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W 189	Continued From page 28 At the time of the observation, the three staff were not observed to utilize/implement a block technique as recommended in Client #2's BSP. Note: During Client #2's physical aggression episode three staff were observed to restrain the client's arms for approximately four minutes (5:26 PM - 5:30 PM). The QMRP's was interview on May 1, 2008 revealed that the facility failed to provide evidence that Staff 1, Staff 2, and the QMRP were trained in the specialized techniques used to manage inappropriate behaviors. It should be further noted that on May 2, 2008, Staff #3 was assigned to work with Client #2. Review of the facility's training record and continued interview with the QMRP failed to provide evidence that Staff 3 was trained in CPI Non-Violence Crisis Intervention Program and/or any other specialized techniques to manage inappropriate behavior. Additional interview with the QMRP on May 1, 2008, at 5:30 PM revealed Client #2's assigned 1:1 staff (Staff #1) had been employed at the facility for less than a month (since April 2008). According to the QMRP, he trained the 1:1 staff on Client #2's BSP. When requested to provide evidence of the training he conducted with the 1:1 staff, the QMRP failed to produce evidence of the aforementioned training. Review of the facility's training records on May 1, 2008 at 6:25 PM, revealed the last training on BSP's was held on January 25, 2008; Client #2's 1:1 staff was not present at that training. It should be further noted that the training sign in sheet failed to specifically identify which BSP's were reviewed. Note: Review of Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History."	W 189		

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W 189	Continued From page 29 According to that section, Client #2 "has a history of needing behavioral support. He has for some time had 1:1 staff support due to concerns regarding intense aggressive and self-injurious behavior. According to MRDDA case manager notes, there have been historic concerns about the qualifications and training of the 1:1 staff..." At the time of the survey, the facility failed to provide evidence that staff were effectively trained in the implementation of Client #1's BSP and failed to provide evidence that staff were trained in the use of special techniques/interventions to manage the client's inappropriate behavior. II. The facility failed to ensure staff were effectively trained to ensure Client #1's protocol for cloth sucking was implemented. (Cross Refer to W149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. It should be noted that at the time of the aforementioned observations, the staff member assigned to work with Clients #1, #3, and #6 was assisting the QMRP and another staff member with a behavioral episode involving Client #2. Review of Client #1's record on May 2, 2008 at approximately 7:40 PM revealed the client had a "Standard Procedure" dated April 10, 2007 that addressed the client's clothe chewing. According to the section entitled "Sucking," Client #1 was to be supplied cloth pieces to chew on that were "at least 6" X 6" so that staff could pull them out of his mouth if he starts to choke or resists giving	W 189	W189 6. In answer to W 189 11, the facility says that When client # 2 went into an explosive behavior and sought to attack a surveyor in the home, an emergency situation erupted. The staff assigned to client # 1 turned to provide assistance in an emergency situation to prevent a surveyor from being hit. It was mere reflex action on the part of the staff with the motive of ensuring safety of a surveyor. As result, staff # 2 assigned to client # 1 could not immediately supervise client # 1 cloth chewing behavior momentarily. However, the staff person will under additional training on emergency situation response in the home.	

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W 189	Continued From page 30 one up." The plan further documented that, "once he has chewed on a clean cloth square for a while, it should be thrown away and [Client #1] should be offered a new one. When he gives up the old one and gets a new one, staff should verbally praise him. Every fifth time he exchanges the old chewed up cloth for a new one, staff should also give him an edible reward, that is consistent with his diet." At the time of the survey, the facility failed to ensure staff were available/trained to address and supervise Client #1 making certain his cloth chewing was conducted in a safe and sanitary manner.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on observations, interview and the review of record, the facility failed to ensure staff were able to demonstrate the skills and techniques necessary to administer interventions to manage each client's behaviors, for two of the three clients (Client's #1 and #2). The finding includes: 1. The facility failed to ensure Client #2's 1:1 staff was able to demonstrate skills necessary to address his exhibited behaviors. (See W189, I) 2. The facility failed to ensure staff were effectively trained to implement Client #1's cloth chewing protocol. (See W189, II)	W 193	W 193 In answer to W 193, the facility hereby cross references and adopts the facility's answers to W 189.	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 31 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, including needed interventions, for one of the three clients (Client #1) included in the sample. The finding includes: Review of Client #1's records on May 2, 2008 at 7:11 PM revealed the client had an Individual Support Plan (ISP) dated April 17, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 and further review of Client #1's ISP revealed program objectives including the following were recommended for upcoming year (2007): - Given physical assistance, [Client #1] will produce the manual signs for "please, eat, and drink" for 5 of 5 trials as measured by program documentation. - Given physical assistance, [Client #1] will participate in a tabletop activity on 3 out of 4 trials a week as recorded per month for three	W 249	W 249 1. All the program goals listed in W 249 except two are ongoing PT programs that were being implemented at time of the survey. 2. The QMRP, who was going through post surgery difficulties during the period, was able to put the programs together the day after the survey. The programs are being implemented. 3. The QMRP has been instructed to ensure that program implementation is not delayed after an ISP no matter what the circumstances may be. The CEO will monitor to ensure that QMRP implements new ISP goals no matter what his personal situation may be and even if will involve making temporary alternative arrangements.	06-02-08 06-03-08 On-going

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consecutive months by April 2008.

- Given verbal assistance, [Client #1] will send a card, piece of art work, or picture to his family member once a month for 6 months by 10/07.

Interview was conducted with the QMRP on May 2, 2008 at 8:02 PM that revealed the client had a new ISP meeting held on April 17, 2008. The QMRP further revealed that a draft ISP document had not been completed and the program with a new objective identified at Client #1's April 2008 ISP had not been implemented. The QMRP supplied some of Client #1's 2008 annual assessments for review. According to the review of Client #1's Physical Therapy Assessment (dated April 17, 2008) and his Social Work Assessment (dated March 25, 2008) the following new program objectives were recommended, but the program failed to be implemented:

- Given physical assistance, Client #1 will participate in shoulder range of motion exercise 10 repetitions, 3 days per week for 12 consecutive months.

- Given verbal prompts, Client #1 will toss and catch a medium sized ball 10 repetitions, 3 days per week for 12 consecutive months.

- Given physical assistance, Client #1 will ambulate for 20 minutes, 3 days per week for 12 consecutive months.

- One time per week, Client #1 will choose his clothing (given two options) that he will wear for the day with verbal assistance for six consecutive months by October 2008.

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W 249	Continued From page 33 At the time of the survey, the facility failed to ensure Client #1's new program objectives were implemented timely as required.	W 249		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on interview and record review, the facility failed to ensure general and preventative care services, for two of the three clients (Clients #1 and #2) included in the sample. The findings include: 1. The facility failed to ensure Client #1 received stool test as directed by the client's Primary Care Physician (PCP). Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at 2:11 PM revealed an incident involving Client #1 dated December 31, 2007. According to the incident report, Client #1 was sent to the emergency room due to some vomiting and prolonged diarrhea. The client was evaluated and diagnosed with acute gastroenteritis. Client #1 was released on January 1, 2008. Review of Client #1's medical records on May 2, 2008 at approximately 2:06 PM revealed a PCP note dated January 7, 2008. According to the note, the PCP wanted a "stool guaiac, ova and	W 322	W 322 In answer to W 322, the facility says as follows: 1. The stool test could not be immediately completed because client # 1 toilets independently and flushes the toilet after use. He also does not make bowel movement frequently. All efforts by staff to get the stool for the test failed. The physician was/is aware of attempts and failures. 2. The nurse has been re-trained to ensure prompt processing of prescription orders and medication delivery in a timely manner. If there are concerns regarding the orders of outside physicians, as in this case there was, then the primary care physician will review the order and determine whether to proceed or treat alternatively.	06-04-08

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W 322	Continued From page 34	W 322		

parasite test completed. Interview with the facility's Registered Nurse on May 2, 2008, revealed the test was not conducted. At the time of the survey, the facility failed to ensure Client #1 received the aforementioned required test.

2. The facility failed to ensure Client #1 received his antibiotic treatment in a timely manner.

Review of the facility's incident reports on May 1, 2008 at 2:11 PM revealed an incident involving Client #1 dated September 12, 2007. According to the report, Client #1 was taken to the emergency room due to weakness. Review of Client #1's nursing note dated September 13, 2007 revealed that the client was diagnosed with Bronchitis and prescribed Levaquin in the emergency room .

Continued review of Client #1's record revealed the client was seen by his Primary Care Physician (PCP) on September 15, 2007. According to the physician note (September 15, 2007), the client was diagnosed with Bronchitis and prescribed "complete Levaquin regimen." Review of Client #1's September 2007 Medication Administration Record (MAR) however, revealed the medication (Levaquin) did not begin until September 18, 2007 (5 days after it was initially prescribed). At the time of the survey, the facility failed to ensure Client #1 received his antibiotic medication in a timely manner.

3. The facility failed to ensure Client #1 was provided with his Erythromycin Ointment in a timely manner.

Review of Client #1's medical record on May 2, 2008 at 2:35 PM revealed the client was seen by

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W 322	Continued From page 35 an Ophthalmologist on January 17, 2008. According to the consultation sheet, the client was prescribed Erythromycin Ointment to his eyes at bedtime. Interview with the facility's Registered Nurse and review of Client #1's January 2008 Physician's Orders (POS) revealed the client's first dose of Erythromycin Ointment was received on January 31, 2008 (fourteen days after it was prescribed). At the time of the survey, the facility failed to ensure Client #1 received his initial dose of Erythromycin in a timely manner.	W 322	3. The nurses have been re-trained to ensure prompt processing of all physician orders in a timely manner. This includes initiation and discontinuation of meds.	06-15-08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, interview, and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs, for four of the six clients (Clients #1, #2, and #5 and #6) that resided in the facility. The finding includes: 1. The facility failed to ensure Client #1 was provided with sunscreen as recommended. Observation on May 2, 2008 at 5:50 PM revealed Client #1 left the facility with staff and housemates to go to dinner. The client was not observed to receive any topical creams before leaving for the evening. Review of Client #1's medical records on May 2, 2008 at 12:15 PM revealed the client's April 2008	W 331		

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W 331	Continued From page 36 Physician's Orders (POS) that documented the client had medical diagnoses including Vitiligo. Further review of Client #1's record on May 2, 2008 at 3:34 PM revealed the client was last seen by the dermatologist on March 14, 2006. According to the consultant, it was recommended that Client #1 use sunscreen when outdoors. Interview was conducted with the nurse on May 2, 2008 to ascertain information about the recommended sunscreen. It should be noted that observation of the facility's environment and observation of the client throughout the survey failed to provide evidence that the client had and/or received the recommended sunscreen. It should be further noted that review of the client's POS additionally failed to provide evidence that the sunscreen had been ordered and/or discontinued. At the time of the survey, the facility failed to ensure Client #1 was provided with the recommended sunscreen to address his medical diagnosis of Vitiligo. 2. The facility failed to ensure its nursing personnel administered/monitored each client treatments. Observation on the evening medication administration on April 30, 2008 beginning at 5:10 PM and concluding at 5:51 PM revealed each client received medications from the residential nurse. After the medications were administered, the corresponding Medication Administration Records (MARs) for each client was reviewed and revealed that three clients had treatment orders that were signed off as given by the nurse. Observation during the medication administration revealed that the following treatments /medications were not given as evidenced below:	W 331	W 331 1. The QMRP and the nurse have instructed the House Manager and staff to consistently apply sunscreen on client #1 when he is going outside during the day. Staff retraining on client # 1 use of sunscreen will be 6/13/08. 2. The nurse instructed the staff to give the topical medication as they are administered with staff assistance after bathing. (PCP orders allow this assistance.) The individual that administers the topical application should sign that they provided the treatment. The nurses have been trained on the format of documentation that is needed.	06-13-08 06-16-08

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W 331	Continued From page 37 a. Client #1 was prescribed Hydrophor ointment to the arms and legs every evening at 6:00 PM and Protopic 0.1% ointment. The ointments were signed off as given by the nurse but not observed during the medication administration. b. Client #2 was prescribed Ketoconazole 2% cream. The cream was signed off as given by the nurse but not observed during the medication administration. c. Client #5 was prescribed Nizorol 2% cream twice day (once at 7:00 PM) and Laclotion 12% lotion (to be given at 6:00 PM). The topicals were signed off as given by the nurse but not observed during the medication administration. At the time of the survey, the facility failed to implement a system that ensured nursing personnel administered and/or monitored the administration of the client's topical medications. 3. The facility's nursing services failed to ensure an effective system that documented discontinued medications/treatments was implemented. Observation of the medication administration on April 30, 2008 at 5:33 PM revealed the client was administered his medication (Carbidopa/Levodopa). Review of Client #1's April 2008 Physician's Orders (POS) on May 2, 2008 at 12:15 PM revealed an order for Erythromycin Ophth 5mg/gm ointment to be applied to each eye every evening. The Erythromycin was not observed to be administered during the evening observation (April 30, 2008). Continued review of the POS	W 331	W331 3. All the medication nurses in the facility have received new instructions and retraining on medication administration policy. The nurse has been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will monitor to ensure that the nurses strictly comply with the facility's medication administration policy.	06-16-08

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W 331	Continued From page 38 revealed the hand written notation "D/C'd" was documented adjacent to the Erythromycin order. It should be noted that notation failed to be initialed or dated by the person that made the notation. Additionally, the printed POS had an area designed on the form for the documentation of discontinued medications. The area made provision for date, time, and person initials to be documented. Interview was conducted with the facility's Registered Nurse (RN) on May 2, 2008, to ascertain information about the Client #1's Erythromycin. According to the RN, the medication was discontinued on March 27, 2008, the date Client #1's April 2008 POS was signed by the physician. Review of Client #1's Medication Administration Record on May 2, 2008, however, revealed the Erythromycin was administered until March 30, 2008. At the time of the survey, the actual discontinuation date for Client #1's Erythromycin could not be determined. 4. The facility's nursing personnel failed to ensure medications were administered at the appropriate times in accordance with their "Medication Administration" policy. Observation on the evening medication administration on April 30, 2008 beginning at 5:10 PM and concluding at 5:51 PM revealed each client received medications. Review of the corresponding Medication Administration Records (MARs) for each client directly after the medication administration revealed clients were scheduled to receive medications at different times, for example: Client #1 was scheduled to receive his	W 331	W331 4. All the medication nurses in the facility have received new instructions and retraining on medication administration policy. The DON will monitor to ensure that the nurses strictly comply with the facility's medication administration policy/schedule.	06-16-08

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W 331	Continued From page 39 Carbidopa/Levodipa at 7:00 PM. The client was administered his medication at 5:33 PM. Client #5 was scheduled to receive his Haldol and Naltrexone Hydrochloride at 7:00 PM. The client received his medications at 5:23 PM. Client #6 received his medications including Amoxicillin and Simvastatin at 5:18 PM. The Amoxicillin was scheduled to be administered at 7:00 PM. The Simvastatin was scheduled to be administered at bedtime. Review of the facility's "Medication Administration" policy on May 2, 2008 revealed that "medications may be administered within a window of one hour prior to and up to one hour after the prescribed time." At the time of the survey, the facility failed to ensure the implementation of its "Medication Administration" policy making certain that medications were administered at the scheduled time. 5. The facility failed to ensure that Client #3's day program administered medications in compliance with his physician's orders. (See W368) 6. The facility's nursing personnel failed to ensure interim orders were correctly documented and signed by the physician timely. (Cross Refer to W368, 1] Review of the medical records at Client #3's day program on May 1, 2008, revealed a physician's order dated July 2007 that documented the client should receive Aurodex drops to both ears twice daily (one of the prescribed doses was to be administered at the day program). Review of Client #3's medical records at the residential facility on May 2, 2008	W 331	5. The QMRP and client # 3 day program had a meeting to ensure that the day program administers medication in compliance with physician orders. The DON and the QMRP will more aggressively monitor medication administration in the day programs to ensure that physician orders are strictly complied with. 6. The DON has instructed the nurse to clearly indicate when she receives telephone orders from the physician and sign and date the order as provided. The nurse as also been instructed to ensure all physician telephone orders are subsequently signed off by the physician. The DON will monitor the administrative nurse to ensure compliance with these procedures.	04-28-08 06-16-08 06-16-08 On-going

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W 331	Continued From page 40 however, revealed an written interim order dated March 31, 2008 that discontinued the aforementioned Aurodex ear drops. Continued review of the interim order revealed the order was signed by the facility's Licensed Practical Nurse but not signed/reviewed by the primary care physician. Additionally, the interim order written by the nurse failed to identify how the order was received (i.e. telephone order). It should be noted that review of the April 2008 Physician's Orders documented the Aurodex drops were discontinued on March 3, 2008. At the time of the survey, the facility failed to provide evidence that the nursing personnel accurately documented physician's orders and ensured the orders were reviewed by the primary care physician.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for two of the three clients (Clients #1 and #3) included in the sample. The findings include: 1. The facility failed to ensure that Client #3's day program administered medications in compliance with his physician's orders. Interview with the day program's nurse on May 1, 2008 at 11:25 AM revealed Client #3 received ear	W 368	W 368 In response to W 368, the facility says as follows: 1. The QMRP and client # 3 day program had a meeting to ensure that the day program administers medication in compliance with physician orders.	04-28-08

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W 368	Continued From page 41 drops as needed (PRN) at the day program for pain. Review of the medical records at Client #3's day program on May 1, 2008, revealed a physician's order dated July 2007 that documented the client should receive Aurodex drops to both ears twice daily (one of the prescribed doses was to be administered at the day program). Review of the Client #3's day program Medication Administration Records (MAR) on May 1, 2008 however, failed to provide evidence that the client was receiving the medication as prescribed. The MARs for the months of July 2007 through February 2008 failed to provide evidence that the client received the ear drops on a daily basis as ordered. At the time of the survey the facility failed to ensure Client #3 received his ear drops in accordance with his physician's order. 2. The facility failed to ensure Client #1's Erythromycin was administered in accordance with the physician's orders. (See W331, 3)	W 368		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on observation and interview, the facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit. The finding includes:	W 426	2. The DON and QMRP will more aggressively monitor the residential nurse and the day program nurse to ensure a more consistent administration of drugs in compliance with physician orders.	06-16-08 On-going

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W 426	Continued From page 42 During the environmental inspection on May 2, 2008, the hot water in the facility was noted to fluctuate between 115 and 120 degrees. Staff were interviewed to ascertain information about the client's access to the hot water during bath times. Staff indicated that the clients required supervision during bathing and required staff to set the water temperature. At the time of the survey, the facility failed to ensure the hot water temperature did not exceed 110 degrees.	W 426	W426 1. At the time of the survey, the water temperature was about 112 degrees Fahrenheit when water was tested with a new thermometer. The temperature was further regulated by turning down the thermostat on the water heater.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation and interview, the facility failed to ensure necessary adaptive equipment was maintained in good repair, for one of the three clients (Client #1) included in the sample. The finding includes: Observation and interview with the Qualified Mental Retardation Professional (QMRP) during the environmental walkthrough on May 2, 2008, beginning at approximately 2:57 PM revealed Client #1 had adaptive feeding equipment including a built-up handled spoon. The handle of the spoon was observed to be melted and indented. Interview was conducted with the facility's QMRP to ascertain if replacement	W 436	The QMRP will monitor the temperature checks logs and ensure that the hot water temperature does not exceed 110 degrees.	

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W 436	Continued From page 43 utensils were on site and available for Client #1's usage. The QMRP revealed that utensils were available and proceeded to search the kitchen drawers to present them to surveyor. At the time of survey, however, the QMRP failed to provide evidence of the replacement utensils. The facility failed to maintain Client #1's built-up handled spoon in good repair.	W 436	W 436 In response to W 436, the facility answers as follows: 1. Client # 1 built-up spoon was good until few days to the survey. The spoon has been replaced. The QMRP shall monitor the service and maintenance of utensils of client # 1 and the other clients in the facility on a regular basis.	06-16-08 On-going
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, the facility failed to ensure that procedures for prevention of communicable disease were implemented for one of the three clients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures to prevent communicable disease were adequately implemented.	W 455	W 455 We acknowledge that the habit of client #1 is unsavory and places him at some risk for acquiring an illness; hence, the BMP. The staff person assigned to assist client #1 was temporarily unavailable to witness the referenced time period of the behaviors due to the behavioral crisis of another person who required additional staff assistance. However, the staff shall implement the "Standard Procedure" as reflected in theBMP.	06-16-08

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I 000	INITIAL COMMENTS Surveyor: 17620 A relicensure survey was conducted from April 30, 2008 through May 2, 2008. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation and interview, the facility failed to ensure all bathrooms were equipped with toilet paper holders, cups and cup dispensers, for three of the six residents (Residents #2, #4 and #5) that resided in the facility. The finding includes: 1. During the environmental inspection on May 2, 2008 beginning at 2:57 PM revealed Residents #2 ,#4 and #5's bathrooms failed to have cup dispensers and/or cups. Additionally, toilet paper was observed to be housed on the back of the toilet in Residents #4 and #5's bathroom (no toilet paper holder). Interview with the facility' s House Manager on May 2, 2008 revealed that the aforementioned needed items would be obtained.	I 082	1082 As answer to 1082, the facility says as follows: 1. The bathrooms used by clients # 2, # 4, #5 and indeed all the residents are now fully equipped with toilet paper holders, cups and cup dispensers 2. The hole in the wall in the referenced bathroom has been repaired.	5/15/8 ongoing 5/15/8

Glen J. Wilson President/COO — TITLE — (X6) DATE 06-11-2008

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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	09G161	A. BUILDING _____ B. WING _____	05/02/2008

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I 082	Continued From page 1 2. The bathroom located on the left side of the house, closes to the dining room was observed to have a large hole on the wall behind the door.	I 082		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation and interview with the Qualified Mental Retardation Professional and/or House Manager during the environmental walkthrough on May 2, 2008 revealed the following: Hallway The exit door closest to Residents #2 and #4's bedrooms was observed to have an area at the right base of the door where the weather stripping was missing and/or not secured. Bedrooms 1. Resident #5's lamp was inoperable (no bulb). 2. Resident #5's brown comforter was observed to be stained. There were dark stains present	I 090		

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I 090	Continued From page 2 and white marks towards the top end of the comforter that covered the resident's pillow. Additionally, Resident #6's comforter was observed to be stained with some white marks. 3. Resident #5's pillowcase was worn and a large tear was observed in its seam. 4. Resident #4's white bed covering had several tears located at the top/upper edge of the covering closest to the head of the bed. 5. Residents #3, #4 and #5's toothbrushes were observed to be housed in their hygiene kits with no covers protecting them. Additionally, Residents #1, #3, #4 and #5's hygiene kits were observed to have open bars of soap that were maintained in the cardboard container that originally housed the soap. 6. There was a large white bottle observed in Resident #4's hygiene kit that failed to be labeled. 7. The radio in Resident #2's bedroom was inoperable. 8. The carpet leading to the entrance of Resident #6's bedroom was torn posing a potential trip hazard. Living Room/TV Room 1. The ceiling dome light located outside the House Manger/Qualified Mental Retardation Professional's office was inoperable. 2. The track lighting in the television room was inoperable. 3. A bulb was missing in the row of track lighting	I 090	As answer to 1090, the facility responds as follows: The weather stripping near at the hallway exit has been repaired. 1. Resident # 5 lamp has a working light bulb. 2. Resident # 5 comforter has been has been cleaned. His turn pillow case replaced. 3. Resident # 6 comforter has been cleaned. 4. Resident # 4 turn white bed covering has been replaced. 5. Residents #3, #4 and #5 now has new protecting covers. Also, residents #1, #3, #4 and #5 are in soap containers. 6. The white bottle in client # 4 hygiene kits has been labeled accordingly. 7. Radio was removed. 8. The carpet leading to resident # 6 room has been trimmed and the potential hazard removed. Living Room/ TV Room The ceiling dome light, the tracking light and the track are now functional and the missing light bulb replaced.	5/15/08 5-15-08

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I 090	Continued From page 3 in the living room.	I 090	1180: [#1.]Please reference the responses cited below. As answer to W 104, the facility hereby cross-references and adopts the answers to W 149 and W 189. The Governing Body will ensure that all staff is re-trained with follow up re-training (60-90 days after 1st session) in concerned areas. Supervising staff will be required to provide job practice monitoring to assess carry-over of information and procedures that reflect current policies of the organization.	6-16-08
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The finding includes: 1. The facility failed to provide continuous active treatment services. [See Federal Deficiency Report Citation W104 and W249] 2. The facility failed to ensure that its Qualified Mental Retardation Professional (QMRP) adequately monitored, integrated, and coordinated each resident's active treatment program [See Federal Deficiency Report Citation W159]	I 180	W 249 1. All the program goals listed in W 249 except two are ongoing PT programs that were being implemented at time of the survey. 2. The QMRP, who was going through post surgery difficulties during the period, was able to put the programs together the day after the survey. The programs are being implemented. 3. The QMRP has been instructed to ensure that program implementation is not delayed after an ISP no matter what the circumstances may be.	4/28/8 6/10/8 4/28/8
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive	I 229		

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I 229	Continued From page 4 technologies; This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the GHMRP failed to ensure staff were effectively trained on the implementation and documentation of each resident's behavior support plan, for two of the three residents (Residents #1 and #2) included in the sample. The finding includes: The facility failed to provide evidence that the direct care staff were able to demonstrate competency in the implementation of each resident's Behavior Support Plan (BSP) and behavior protocol. (See W189 and W193)	I 229	The CEO will monitor to ensure that QMRP implements new ISP goals no matter what his personal situation may be and even if will involve making temporary alternative arrangements. In response to W 159(1) cross-references and adopts the answers contained in W 120, 149, 189, 249. 1229 As answer to 1229, the facility says as follows: Consultation with the behavior specialist and psychologist shall be conducted to review revised training curricula on behavior management and individual BSPs. Revisions shall focus on ensuring competency based trainings and reflective of the learning needs of new and current staff members.	4-28-08 6-16-08 7-30-08
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to maintain each residents' records, for one of the three residents (Resident #2) included in the sample. The finding includes: The facility failed to ensure a complete medical assessment was available for review as evidenced below:	I 260		

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I 260	Continued From page 5 Review of Resident #2's medical record on May 2, 2008, at 12:18 PM revealed a medical assessment dated November 8, 2007. Further review of the resident's medical assessment revealed that it had not been signed or dated by the Primary Care Physician (PCP). Interview with the facility's Registered Nurse on May 2, 2008, revealed that some pages were missing from the assessment. At the time of the survey, there was no documented evidence that the resident's medical record was maintained.	I 260	1260 As response to 1260, the facility says as follows: 1. Client # 2 medical assessment was pulled during other third party monitoring visits prior to the survey, and subsequently incorrectly filed. This error was corrected on 5/03/08. The DON and the QMRP will monitor to ensure consistent compliance with proper filing procedures.	5/5/8 ongoing
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the facility failed to ensure that each entry into a client's record was signed and dated, for one of three clients (Client #1) included in the sample. The finding includes: Observation of the medication administration on April 30, 2008 at 5:33 PM revealed the client was administered his medication (Carbidopa/Levodopa). Review of Client #1's April 2008 Physician's Orders (POS) on May 2, 2008 at 12:15 PM revealed an order for Erythromycin Ophthalmology 5mg/gm ointment to be applied to each eye every evening. Continued review of the POS revealed the hand written notation "D/C'd" was documented adjacent to the Erythromycin order. It should be noted that notation failed to be signed or dated by the person that made the notation. Additionally, the printed POS had an area designed on the form	I 291	1291 1. The nurse has been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will more aggressively monitor entries in clients' records to ensure consistent compliance with recording procedures.	6-16-08 On-going

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I 291	Continued From page 6 for the documentation of discontinued medications. The area made provision for date, time, and person's initials to be documented. At the time of the survey, the facility failed to ensure the notation made on Client #1's April 2008 POS was signed and dated.	I 291	1379 As answer to 1379, the facility says as follows: 1. Both the QMRP and the Incident management coordinator have received mandated instructions to notify Department of Health of any incidents involving all the clients in the facility by telephone immediately and in writing within 24 hours. The CEO shall monitor this issue to ensure consistent compliance with the aforesaid instruction. The facility notifies parents/ Guardians of serious incidents as required by the facility's incident management policy. Usually, notifications are done by the QMRP on telephone. These telephone notifications are not reflected on the incident report forms reviewed by the surveyors. However, the facility reviewed its parent /guardian notification system on 6/04/08 and henceforth all telephone notifications must be reflected on the file copy of the incident report in the facility as additional note.	6/16/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for two of the six residents (Residents #2 and #6) that resided in the facility. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on May 1, 2008, beginning at 2:11 PM revealed the following:	I 379		

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I 379	Continued From page 7 On April 27, 2008, staff reported that Resident #6 fell and hit his right eye and left hand on the corner of his nightstand. The client was taken to the emergency room for evaluation and treatment. On December 31, 2007, staff reported that Resident #6 was taken to the emergency room due to being unable to walk. The client was treated at the emergency room and diagnosed with fatigue. On October 25, 2007, staff reported that Client #2 fell and hit his mouth which resulted in the resident cracking/breaking his right front tooth. At the time of the survey, the facility failed to ensure the Department of Health notified of the aforementioned incidents as required (both immediately and provided with written notification within 24 hours).	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the GHMRP failed to ensure general and preventative care services, for two of the three residents (Resident #1) included in the sample. The findings include:	I 401		

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I 401	Continued From page 8 1. The facility failed to ensure Resident #1 received stool test as directed by the resident's Primary Care Physician (PCP). Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at 2:11 PM revealed an incident involving Resident #1 dated December 31, 2007. According to the incident report, Resident #1 was sent to the emergency room due to some vomiting and prolonged diarrhea. The resident was evaluated and diagnosed with acute gastroenteritis. Resident #1 was released from the emergency room on January 1, 2008. Review of Resident #1's medical records on May 2, 2008 at approximately 2:06 PM revealed a PCP note dated January 7, 2008. According to the note, the PCP wanted a "stool guaiac, ova and parasite test completed. Interview with the facility's Registered Nurse on May 2, 2008, revealed the test was not conducted. At the time of the survey, the facility failed to ensure Resident #1 received the aforementioned required test. 2. The facility failed to ensure Resident #1 received his antibiotic treatment in a timely manner. Review of the facility's incident reports on May 1, 2008 at 2:11 PM revealed an incident involving Resident #1 dated September 12, 2007. According to the report, Resident #1 was taken to the emergency room due to weakness. Review of Resident #1's nursing note dated September 13, 2007 revealed that the resident was diagnosed with bronchitis and was prescribed	I 401	1401 As response to 1401, the facility says as follows: 1. The stool test could not be immediately completed because client # 1 toilets independently and flushes the toilet after use. He also does not make bowel movement frequently. All efforts by staff to get the stool for the test failed. The physician was/is aware of attempts and failures. 2. The nurse has been re-trained to ensure prompt processing of prescription orders and medication delivery in a timely manner. If there are concerns regarding the orders of outside physicians, as in this case there was, then the primary care physician will review the order and determine whether to proceed or treat alternatively.	6/4/08 6/4/08 On-going

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I 401	Continued From page 9 Levaquin in the emergency room. Continued review of Resident #1's record revealed the Resident was seen by his Primary Care Physician (PCP) on September 15, 2007. According to the physician note (September 15, 2007), the resident was to "complete Levaquin regimen." Review of Resident #1's September 2007 Medication Administration Record (MAR) however, revealed the medication (Levaquin) did not begin until September 18, 2007 (5 days after it was initially prescribed). At the time of the survey, the facility failed to ensure Resident #1 received his antibiotic medication in a timely manner. 3. The facility failed to ensure Resident #1 was provided with his Erythromycin Ointment in a timely manner. Review of Resident #1's medical record on May 2, 2008 at 2:35 PM revealed the resident was seen by an Ophthalmologist on January 17, 2008. According to the consultation sheet, the resident was prescribed Erythromycin Ointment to his eyes at bedtime. Interview with the facility's Registered Nurse and review of Resident #1's January 2008 Physician's Orders (POS) revealed the resident's first dose of Erythromycin Ointment was received on January 31, 2008 (fourteen days after it was prescribed). At the time of the survey, the facility failed to ensure Resident #1 received his initial dose of Erythromycin in a timely manner. 4. The facility failed to ensure Resident #1 was provided with sunscreen as recommended. Observation on May 2, 2008 at 5:50 PM revealed Resident #1 left the facility with staff and his	I 401	3. The nurses have been re-trained to ensure prompt processing of all physician orders in a timely manner. This includes initiation and discontinuation of meds. 4-5. The QMRP and the nurse have instructed the House Manager and staff to consistently apply sunscreen on client #1 when he is going outside during the day. Staff retraining on client # 1 use of sunscreen will be 6/13/08.	6-16-08 ongoing 6-13-08

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I 401	Continued From page 10 housemates to go to dinner. The resident was not observed to receive any topical creams before leaving for the evening. Review of Resident #1's medical records on May 2, 2008 at 12:15 PM revealed the resident's April 2008 Physician's Orders (POS) that documented the resident had medical diagnoses including Vitiligo. Further review of Resident #1's record on May 2, 2008 at 3:34 PM revealed the resident was last seen by the dermatologist on March 14, 2006. According to the consultant, it was recommended that Resident #1 use sunscreen when outdoors. Interview was conducted with the nurse on May 2, 2008 to ascertain information about the recommended sunscreen. It should be noted that observation of the facility's environment and observation of the resident throughout the survey failed to provide evidence that the resident had and/or received the recommended sunscreen. It should be further noted that review of the resident's POS additionally failed to provide evidence that the sunscreen had been ordered and/or discontinued. At the time of the survey, the facility failed to ensure Resident #1 was provided with the recommended sunscreen to address his medical diagnosis of Vitiligo. 6. The facility failed to ensure its nursing personnell adminisered/monitored each client treatments. Observation on the evening medication administration on April 30, 2008 beginning at 5:10 PM and concluding at 5:51 PM revealed each resident received medications from the residential nurse. After the medications were administered, the corresponding Medication Administration	I 401	5 The nurse instructed the staff to give the topical medication as they are administered with staff assistance after bathing. (PCP orders allow this assistance.) The individual that administers the topical application should sign that they provided the treatment. The nurses have been trained on the format of documentation that is needed. 6 The nurse instructed the staff to give the topical medication as they are administered with staff assistance after bathing. (PCP orders allow this assistance.) The individual that administers the topical application should sign that they provided the treatment. The nurses have been trained on the format of documentation that is needed.	6/16/08 ongoing 6-16-08

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I 401	Continued From page 11 Records (MARs) for each client was reviewed and revealed that three residents had treatment orders that were signed off as given by the nurse. Observation during the medication administration revealed that the following treatments /medications were not given as evidenced below: a. Resident #1 was prescribed Hydrophor ointment to the arms and legs every evening at 6:00 PM and Protopic 0.1% ointment. The ointments were signed off as given by the nurse but not observed during the medication administration. b. Resident #2 was prescribed Ketoconazole 2% cream. The cream was signed off as given by the nurse but not observed during the medication administration. c. Resident #5 was prescribed Nizorol 2% cream twice day (once at 7:00 PM) and Laclotion 12% lotion (to be given at 6:00 PM). The topicals were signed off as given by the nurse but not observed during the medication administration. At the time of the survey, the facility failed to implement a system that ensured nursing personnel administered and/or monitored the administration of the client's topical medications. 7. The facility's nursing services failed to ensure an effective system that documented discontinued medications/treatments was implemented. Observation of the medication administration on April 30, 2008 at 5:33 PM revealed the resident was administered his medication (Carbidopa/Levodopa). Review of Resident #1's April 2008 Physician's Orders (POS) on May 2,	I 401	7. The QMRP and client # 3 day program had a meeting to ensure that the day program administers medication in compliance with physician orders. The DON and the QMRP will shall monitor more closely medication administration in the day programs to ensure that physician orders are strictly complied with.	6-16-08

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I 401	Continued From page 12 2008 at 12:15 PM revealed an order for Erythromycin Ophth 5mg/gm ointment to be applied to each eye every evening. The Erythromycin was not observed to be administered during the evening observation (April 30, 2008). Continued review of the POS revealed the hand written notation "D/C'd" was documented adjacent to the Erythromycin order. It should be noted that notation failed to be initialed or dated by the person that made the notation. Additionally, the printed POS had an area designed on the form for the documentation of discontinued medications. The area made provision for date, time, and person initials to be documented. Interview was conducted with the facility's Registered Nurse (RN) on May 2, 2008, to ascertain information about the Resident #1's Erythromycin. According to the RN, the medication was discontinued on March 27, 2008, the date Resident #1's April 2008 POS was signed by the physician. Review of Resident #1's Medication Administration Record on May 2, 2008, however, revealed the Erythromycin was administered until March 30, 2008. At the time of the survey, the actual discontinuation date for Resident #1's Erythromycin could not be determined.	I 401	8. The nurse has been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will more aggressively monitor entries in clients' records to ensure consistent compliance with recording procedures	6-16-08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation interview and record review, the GHMRP failed to ensure habilitation,	I 422	1422 As answer to 1422, the facility hereby cross-references and adopts the answers to 1180.	ongoing

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I 422	Continued From page 13 training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for three of the three residents (Residents #1, #2 and #3) included in the sample. The finding includes: I. The facility failed to ensure that outside services met each clients active treatment needs. (See Federal Deficiency Report Citation W120) II. The facility failed to ensure each client received continuous active treatment services, including needed interventions. (See Federal Deficiency Report Citation W249) III. I. The facility failed to provide evidence that Client #2's 1:1 staff was trained on his Behavior Support Plan (BSP) including the use of special techniques/interventions to manage the client's inappropriate behavior. Observations on May 1, 2008 beginning at 5:09 PM revealed a 1:1 direct care staff (Staff #1) escorting Client #2 to the facility's TV room. At 5:15 PM, the client and his 1:1 staff were observed seated on the sofa in the in the TV room directly behind Surveyor A. At approximately 5:26 PM, Surveyor B observed Client #2 heading rapidly towards Surveyor A with both of his arms extended (Surveyor A's back was facing the client). Surveyor B assisted Surveyor A by moving Surveyor A out of the reach of Client #2. The client was observed to be physically aggressive and began to yell and scream. Continued observation during the aggressive episode revealed Client #2's 1:1 staff (Staff #1)	I 422		

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I 422	Continued From page 14 attempted to prevent the aggression towards Surveyor A by pulling the client. Client #2 was then observed to head down the hallway towards his bedroom, but prior to getting to the hallway, Client #2 hit Surveyor A. Afterwards, Client #2 proceeded down the hallway with his 1:1 staff person holding onto his arm. At that time, the direct care staff person assigned to work with Clients #1, #3 and #6 (Staff #2) and the Qualified Mental Retardation Professional (QMRP) were observed to assist in the intervention of Client #2's behavior. The three staff were observed to have difficulty redirecting the client. They were observed to restrain both of Client #2's arms for approximately three minutes. Once the client appeared to be calm the staff escorted Client #2 outside of the facility. Interview with the QMRP on May 2, 2008 at 5:30 PM revealed that Client #2 had a Behavior Support Plan (BSP) that addressed behaviors of self injurious behaviors, physical aggression (such as scratching and hitting people) and throwing objects. The QMRP's statement was verified on May 2, 2008 through review of Client #2's BSP dated November 17, 2007. According to the plan, in a section entitled "Intervention Procedures for Physical Aggression," the following procedures were to be implemented: 1. If [client's name] engages in aggression, he will be given the verbal directive, "Stop [client's name]." At the time of the observation, the three staff were not observed giving a directive for Client #2 to " stop." 2. If [client's name] continues displaying aggressive behaviors staff should assume the "CPI Supportive Stance" as trained in the "Non-Violence Crisis Intervention Program."	I 422		

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I 422	Continued From page 15 Interview was conducted with the QMRP on May 1, 2008 at 5:30 PM to ascertain information regarding which staff was trained on specialized techniques to manage inappropriate behavior (CPI Supportive Stance and Non-Violence Crisis Intervention Techniques). At the time of the survey, the facility failed to provide evidence that the QMRP, Staff 1 and Staff 2 had been trained in the aforementioned techniques. It should be noted that during the observation there was no evidence that the staff addressing Client #2's behaviors assumed the supportive stance documented in the client's BSP. 3. Staff should remember to consider such things as personal space (remain about 1-3 feet away) and body posture/motion (keep your hands open and facing upward). At the time of the observation, the three staff were in close proximity of Client #2. Additionally, the staff's hands were not positioned as indicated in the aforementioned intervention. It should noted that all three staff were observed to restrain the client's arms. 4. In the event that the behavior escalates, staff will utilize a block technique (learned in NVCI, see instructors' Manual) to interrupt the behavior(s). At the time of the observation, the three staff were not observed to utilize/implement a block technique as recommended in Client #2's BSP. Note: During Client #2's physical aggression episode three staff were observed to restrain the client's arms for approximately four minutes (5:26 PM - 5:30 PM). The QMRP's was interview on May 1, 2008 revealed that the facility failed to provide evidence that Staff 1, Staff 2, and the QMRP were trained in the specialized techniques	I 422		

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I 422	Continued From page 16 used to manage inappropriate behaviors. It should be further noted that on May 2, 2008, Staff #3 was assigned to work with Client #2. Review of the facility's training record and continued interview with the QMRP failed to provide evidence that Staff 3 was trained in CPI Non-Violence Crisis Intervention Program and/or any other specialized techniques to manage inappropriate behavior. Additional interview with the QMRP on May 1, 2008, at 5:30 PM revealed Client #2's assigned 1:1 staff (Staff #1) had been employed at the facility for less than a month (since April 2008). According to the QMRP, he trained the 1:1 staff on Client #2's BSP. When requested to provide evidence of the training he conducted with the 1:1 staff, the QMRP failed to produce evidence of the aforementioned training. Review of the facility's training records on May 1, 2008 at 6:25 PM, revealed the last training on BSP's was held on January 25, 2008; Client #2's 1:1 staff was not present at that training. It should be further noted that the training sign in sheet failed to specifically identify which BSP's were reviewed. Note: Review of Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2 "has a history of needing behavioral support. He has for some time had 1:1 staff support due to concerns regarding intense aggressive and self-injurious behavior. According to MRDDA case manager notes, there have been historic concerns about the qualifications and training of the 1:1 staff..." At the time of the survey, the facility failed to provide evidence that staff were effectively trained in the implementation of Client #1's BSP and failed to provide evidence that staff were trained in the use of special	I 422		

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I 422	Continued From page 17 techniques/interventions to manage the client's inappropriate behavior. IV. The facility failed to ensure staff were effectively trained to ensure Client #1's protocol for cloth sucking was implemented. (Cross Refer to W149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. It should be noted that at the time of the aforementioned observations, the staff member assigned to work with Clients #1, #3, and #6 was assisting the QMRP and another staff member with a behavioral episode involving Client #2. Review of Client #1's record on May 2, 2008 at approximately 7:40 PM revealed the client had a "Standard Procedure" dated April 10, 2007 that addressed the client's clothe chewing. According to the section entitled "Sucking," Client #1 was to be supplied cloth pieces to chew on that were "at least 6" X 6" so that staff could pull them out of his mouth if he starts to choke or resists giving one up." The plan further documented that, "once he has chewed on a clean cloth square for a while, it should be thrown away and [Client #1] should be offered a new one. When he gives up the old one and gets a new one, staff should verbally praise him. Every fifth time he exchanges the old chewed up cloth for a new one, staff should also give him an edible reward, that is consistent with his diet." At the time of the survey, the facility failed to ensure staff were available/trained to address and supervise Client #1 making certain his cloth chewing was conducted in a safe and sanitary manner. (See	I 422		

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I 422	Continued From page 18 Federal Deficiency Report Citation W149, 2)	I 422	As answer to 1434, the facility responds as follows:	
I 434	3521.7(d) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (d) Dressing (including purchasing, selecting, and access to clothing); This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the facility failed to ensure residents were effectively trained in the area of privacy, for two of the three (Residents #1 and #3) included in the sample. The findings include: 1. Observations conducted on May 2, 2008, at 4:36 PM revealed Resident #3 received staff assistance while using the bathroom. The resident was observed seated on the toilet with the bathroom door opened. At the time of the survey the facility failed to ensure the resident's right to privacy was provided during his personal care. 2. Observation of Resident #1 on May 1, 2008 at 5:46 PM, revealed Resident #1 was observed with his buttocks exposed in the television room (pants down). Resident #4's 1:1 attempted to assist Resident #1 by escorting him from the television room through the dining room (with his buttocks still exposed and Resident #4 accompanying them) to get dressed. It should be noted that at the time of the aforementioned observation, the staff member assigned to work	I 434	1. Staff is instructed to monitor client # 3 while using the bathroom because client # 3 fainted while using the bathroom in 2007 and was taken to hospital, treated and discharged. However, the facility will conduct further staff training on client privacy rights and protection to ensure a reasonable balance between monitoring client # 3 and the need to protect his privacy at all times. 2. When client # 2 went into an explosive behavior and sought to attack a surveyor in the home, an emergency situation emerged. The staff assigned to client # 1 turned to provide assistance in an emergency situation to prevent a surveyor from being hit. It was mere reflex action on the part of the staff with the motive of ensuring safety of a surveyor. Unfortunately, within this short time client # 1 pant partially pulled and exposed his underwear. However, the staff in question and other staff members will be retrained on privacy right and protection of client # 1 as well as other clients in the facility. The staff will also be retrained on how to respond in an emergency situation.	6/10/8 ongoing 6/4/8 ongoing 6-16-08

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I 434	Continued From page 19 with Residents #1, #3 and #6 was assisting the QMRP and another staff member with a behavioral episode involving Resident #2. At the time of the survey, the facility failed to ensure Resident #1's right to privacy during dressing.	I 434		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the GHMRP failed to ensure the protections of each client's rights. The findings include: (See Federal Deficiency Report Citations W102, W122, W124, and W158)	I 500	1500 In response to 1500, please reference responses to Federal Deficiency Report Citations W 102, W122, W124 and W158.	